Athlete Application for Participation

(Valid for 3 Years from the Date of the Physical Exam)

Special Olympics Massachusetts

Area and Local Program _____

Please print clearly. All information is required.

Name

Social Security Number (optional) ___-___-____ Male ☐ Female ☐ Date of Birth ___/___/____ Phone #: ___-___-____

Street Address or PO Box _____ Apt # _____

City/Town _____ State ____ ZIP Code + 4 _____-____

Emergency Contact Name _____ Emergency Contact Phone # ___-___-____

Last Name, First Name: _____

Form Expiration Date ___/___/___

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
☐	☐	Allergies:	☐	☐	Easy bleeding
☐	☐	*Environmental:* _____	☐	☐	Emotional/psychiatric/behavioral
☐	☐	*Food:* _____	☐	☐	Heart disease/heart defect*
☐	☐	*Insect stings/bites:* _____	☐	☐	Hepatitis
☐	☐	*Medicines:* _____	☐	☐	High blood pressure*
☐	☐	Asthma*	☐	☐	Immunizations up-to-date
☐	☐	Blind*	☐	☐	*Date of last tetanus immunization* ___/___/___
☐	☐	*Visually impaired*	☐	☐	Needs medication (see "Medications" table below)
☐	☐	Bone or joint problem	☐	☐	Requires extra supervision
☐	☐	Concussion or serious head injury*	☐	☐	Seizures/epilepsy/fainting spells*
☐	☐	Deaf	☐	☐	Shunts
☐	☐	*Hearing impaired*	☐	☐	Special diet
☐	☐	Diabetes*	☐	☐	Tobacco use
☐	☐	Down Syndrome (see below)	☐	☐	Other: _____

(*) Requires physical examination if new problem

Medications (if applicable): Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

Special Olympics Massachusetts (SOMA) specifically has my permission (both during participation and anytime thereafter) to use my/my child's/my ward's likeness, name, voice, and words in television, radio, film, newspaper, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics Massachusetts.

I understand that if a medical emergency should arise during my/my child's/my ward's participation in any SOMA activity and I am not able to give my consent for treatment, that SOMA is authorized to take whatever measures are necessary to protect my health and well-being including hospitalization.

Signature of parent/legal guardian/adult athlete (over 18) _____ Date ___/___/___

SECTIONS BELOW TO BE COMPLETED BY EXAMINING PHYSICIAN:

For Athletes With Down Syndrome: Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyper flexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes	No	
☐	☐	Has an x-ray evaluation for atlantoaxial instability been done? Date of x-ray: ___/___/___
☐	☐	If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics. **RESTRICTIONS:** _____

Signature of Examiner _____ Exam Date ___/___/___

(no office stamps accepted without provider's signature)

Examiner's Name

Street Address or P.O.

City/Town _____ State ____ ZIP _____ Phone #: ___-___-____

A COPY OF THIS APPLICATION MUST BE FILED AT THE SOMA HEADQUARTERS & EITHER THE AREA OR SECTIONAL OFFICE 3/02

COACHES WILL BE RESPONSIBLE FOR HAVING UP-TO-DATE ATHLETE MEDICAL FORMS IN THEIR POSSESSION AT TRAINING AND COMPETITION EVENTS. THE COACH'S COPIES OF MEDICAL FORMS WILL BE UTILIZED AT ALL QUALIFYING COMPETITIONS AND AREA EVENTS.

Medical forms are evaluated for completeness using the following required information as criteria:

- on the correct form
- area and local program
- full first and last name
- gender
- date of birth
- street address
- city
- home phone number, including area code
- parent/guardian name (if under 18)
- emergency contact name and phone number, including area code
- signature of athlete (18 or older) or signature of parent/guardian
- "history of" medical information on the medical unless supplemented by an attachment which contains the same info
- doctor's/physician's assistant/nurse practitioner's signature (no office stamps allowed)
- date of physical examination
- no fax copies accepted

OVERNIGHT EVENTS

- If medication is to be dispensed by SOMA medical volunteers, it must be accompanied by a medication form *(supplemental medication form)*
- Medication must be in its original container